**PM FORM 3.14.2**
**RE-CERTIFICATION OF NEED (RON)**
**(Level I Facilities)**
**Fax to: (602) 364-4749**

☐ Inpatient Psychiatric Services ☐ C/A Residential Treatment Center

Date Due:
Date and Time RON completed: Date of Admission:
**Client's Name:**_____Client ID# _____D.O.B.: _____
Case Manager:_____ RBHA: _____

1. DSM-IV Diagnostic Codes Axis I _____ Axis II _____ Axis III _____ Axis IV _____ Axis V _____

2. **Reason for Continued Stay**: Check at least **ONE** from both **A** and **B, or C** and check **ALL** that apply from the Continued Stay Criteria below:

**A. Severity of Illness**:

☐ Persistence of disabling symptoms;
☐ Serious adverse reaction or non-response to medication, procedures, or therapy;
☐ Failure to attain treatment goals resulting in continuation of severe impairment of the client's physical, social, or behavioral functioning;
☐ Degree of illness precludes outpatient management; and
☐ Level I treatment course demonstrating lack of discharge readiness; e.g. Absent Without Leave (AWOL), suicide attempt, Dangerous To Others (DTO), Dangerous to Self (DTS)

**B. Intensity of Service**:

☐ Continues to need 24-hour/day close and continuous supervision of psychiatric condition;
☐ Significant impairment continues in familial, social, or academic environment;
☐ Pharmacotherapy with close observation and/or laboratory monitoring, and/or nursing supervision;
☐ Frequent redirection and/or observations which may include the use of time-outs, seclusion and restraint;
☐ The presence of a medical condition significantly hindering the treatment of the psychiatric condition.

**C. Less restrictive resources available in the community still do not meet the treatment needs of the client**.
Yes ☐ No ☐

Specify the alternatives considered, and issues that indicate need for continued stay.

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**D. Discharge Plan**: **Inpatient services can reasonably be expected to improve the client's condition or prevent further regressions**.

Yes ☐ No ☐ Estimated L.O.S. _____

**Current Symptoms and Specific Behavior that support each reason for continued stay from A & B**

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| **Current Medications:** | **Dose** | **Frequency** | **Date Started** |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| **Medication changes in the past 30 days and reasons for the change:** | | | |
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## RE-CERTIFICATION OF NEED

**Client ID# _____ Client Name:_____**

**Describe the clinical plan to resolve the remaining treatment needs** *(i.e. describe the changes to the treatment plan that will foster the attainment of the treatment goals):*

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**3. Mental Status**:

Oriented: ____ (Time, Person, Place, Situation): Level of alertness ☐ Partial ☐ Full

Speech ☐ Normal ☐ Abnormal: Specify_____ Sleeping ☐ Normal ☐ Abnormal: Specify_____

Eating ☐ Normal ☐ Abnormal: Specify_____

Mood ☐ Normal ☐ Depressed ☐ Elevated ☐ Agitated: Specify_____

Affect ☐ Normal ☐ Constricted ☐ Blunted ☐ Other: Specify_____ Mannerisms ☐ Normal ☐ Abnormal: Specify_____

Behavior ☐ Actively participates ☐ Refuses activities or treatment ☐ Cooperative ☐ Uncooperative

Delusions ☐ None ☐ Active: Specify_____

Hallucinations ☐ None ☐ Auditory ☐ Visual ☐ Olfactory

Thought Process ☐ Normal/Logical ☐ Abnormal: Specify_____

Associations ☐ Normal ☐ Abnormal: Specify_____ Stream ☐ Normal ☐ Abnormal: Specify_____

Judgment ☐ Good ☐ Impaired/Limited ☐ Fair ☐ Poor ☐ Other:_____

Insight ☐ Good ☐ Impaired/limited ☐ Fair ☐ Poor ☐ Other:_____

DTS Behaviors: ☐ Recent: specify dates _____ ☐ Potential /At Risk for ☐ None

DTO Behaviors: ☐ Recent: specify dates _____ ☐ Potential /At Risk for ☐ None

| **Disposition/ Discharge Plan and Barriers to Discharge:** |
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I am aware of the client's condition and have been provided sufficient information to determine this level of care is appropriate.

Signature _____ Print Name: _____
(Signature by Physician, Physician Assistant, or Nurse Practitioner)

Date signed:____/____/____

(**Change of diagnosis** requires an amended Re-Certification of Need form signed by the Physician, Physician Assistant or Nurse Practitioner. Please provide the following information: Date and Time RON completed; Date of Admission; Client's Name; Client ID#; D.O.B.; Case Manager; RBHA; and DSM-IV Diagnostic Codes.)